MIDLAND NATIONAL® Life Insurance Company

ICC169401A

GENERAL PURPOSE INDIVIDUAL LIFE INSURANCE APPLICATION (Print and Use Black Ink)

PROPOSED INSURED

1. Last Name: Villarreal

First Name: Paul Middle Initial: M

Social Security or Tax ID No.: Date of Birth (M M D D Y Y Y Y): 1962

1a. Are you a U.S. Citizen or do you have a permanent Visa? ☒ Yes ☐ No (If no, complete Foreign Travel and Residence Questionnaire)

1b. Have you ever used a different name? ☐ Yes ☒ No

If Yes, give name used and time period.

Sex	Age	Place of Birth – State / Country	Height (FT. IN)	Weight (LBS.)	Marital Status
☒ Male ☐ Female	56	TX, USA	5'8	140	S

☒ Driver's License: # Issue State / Country: TX

☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card: #

2. Residence Address (If P.O. Box, include Street Address) Street: 959 Washington ST City: Farmersville State: TX Zip Code: 75442

3. Employer (Company Name and Address): Nine Band Brewing Co

Are you actively employed? ☒ Yes ☐ No

Occupation (Title and Duties): Brewery Asst.

Annual Income: $50,000 Net Worth: $200,000

4. CONTACT THE PROPOSED INSURED AT: 9 (CST) ☒ AM ☐ PM

☒ RESIDENCE
☒ BUSINESS 972 341 4608
☒ MOBILE

PLAN INFORMATION

5. Amount Applied For: $ 400,000

6. Proposed Plan of Insurance: XLEC5

Death Benefit Options For UL: (check one): ☐ Level ☐ Increasing ☐ Return of Premium

Death Benefit Qualification Test, if applicable. Defaults to GPT, if none selected:

☑ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

☐ Minimum Premium ☐ Target Premium ☐ Rebalance - VUL Only

7. RIDERS

a. Term and Whole Life

- ☐ Children's Term Insurance $
- ☐ Other Insured $
- ☐ Accidental Death Benefit $
- ☐ Waiver of Premium
- ☐ Automatic Premium Loan **(Whole Life Only)**
- ☐ Other _____ (Plan) $_____ (Amount)

b. UL, IUL and VUL

- ☐ Premium Guarantee (PGR)
- ☐ Accidental Death Benefit $
- ☐ Children's Term Insurance $
- ☐ Flexible Disability Insurability $
- ☐ Guaranteed Insurability $
- ☐ Waiver of Charges
- ☑ Waiver of Surrender Charge Option
- ☐ Estate Preservation - Survivorship Only
- ☐ Other _____ (Plan) $_____ (Amount)

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA
Phone: (605) 335-5700 • New Business Fax - Red Team: (877) 212-1057 Blue Team: (877) 212-1704 Green Team: (877) 212-1703 • Fax Center: (877) 208-6136 • MidlandNational.com

8. DEPENDENT CHILDREN PROPOSED FOR INSURANCE - Complete ONLY if Children's Term Insurance is applied for

Name: ______ Sex: ☐ Male ☐ Female Height (FT. IN.): ______ Weight (LBS.): ______
Social Security/Tax ID: ______ Date of Birth: ______ State/Country of Birth: ______
Relationship to Proposed Insured: ______
Address: Check box if address is same as ☐ Owner or ☐ Joint Owner, otherwise list below.
______
Telephone Number: Check box if telephone is same as ☐ Owner or ☐ Joint Owner, otherwise list here: ______

Name: ______ Sex: ☐ Male ☐ Female Height (FT. IN.): ______ Weight (LBS.): ______
Social Security/Tax ID: ______ Date of Birth: ______ State/Country of Birth: ______
Relationship to Proposed Insured: ______
Address: Check box if address is same as ☐ Owner or ☐ Joint Owner, otherwise list below.
______
Telephone Number: Check box if telephone is same as ☐ Owner or ☐ Joint Owner, otherwise list here: ______

Name: ______ Sex: ☐ Male ☐ Female Height (FT. IN.): ______ Weight (LBS.): ______
Social Security/Tax ID: ______ Date of Birth: ______ State/Country of Birth: ______
Relationship to Proposed Insured: ______
Address: Check box if address is same as ☐ Owner or ☐ Joint Owner, otherwise list below.
______
Telephone Number: Check box if telephone is same as ☐ Owner or ☐ Joint Owner, otherwise list here: ______

Name: ______ Sex: ☐ Male ☐ Female Height (FT. IN.): ______ Weight (LBS.): ______
Social Security/Tax ID: ______ Date of Birth: ______ State/Country of Birth: ______
Relationship to Proposed Insured: ______
Address: Check box if address is same as ☐ Owner or ☐ Joint Owner, otherwise list below.
______
Telephone Number: Check box if telephone is same as ☐ Owner or ☐ Joint Owner, otherwise list here: ______

Name: ______ Sex: ☐ Male ☐ Female Height (FT. IN.): ______ Weight (LBS.): ______
Social Security/Tax ID: ______ Date of Birth: ______ State/Country of Birth: ______
Relationship to Proposed Insured: ______
Address: Check box if address is same as ☐ Owner or ☐ Joint Owner, otherwise list below.
______
Telephone Number: Check box if telephone is same as ☐ Owner or ☐ Joint Owner, otherwise list here: ______

N/A

To be completed by Parent or Legal Guardian

8a. Has any child proposed for insurance ever been diagnosed or treated by a licensed medical professional for: heart disease; cancer; tumor; diabetes; jaundice; mental disease, bone or muscle disorder; respiratory disease; liver disorder, neurological disease, or alcohol or drug abuse? .... ☐ Yes ☐ No

8b. In the past 5 years, has any child proposed for insurance pled guilty or been convicted of: (1) a moving violation; (2) driving under the influence of alcohol or drugs; or (3) had his/her driver's license suspended or revoked? .... ☐ Yes ☐ No

N/A

Provide details below to "Yes" answers for the above questions. If more space is needed, attach additional sheet, identify question, sign and date.

Question #	Dependent's Name	Details

OWNER INFORMATION

9. Is the Owner or Joint Owner of this policy a full-time active duty Service Member of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard), or dependent thereof? ..... If yes, also complete Military Sales Disclosure form.	Owner	Joint Owner
	☐ Yes ☒ No	☐ Yes ☐ No

Complete the following section(s) ONLY if Owner or Joint Owner, including a Trustee *, is other than the Proposed Insured.

9a. NAME OF OWNER ☐Individual ☐Trust–Also complete Certificate of Trust Agreement ☐Business/Corporate–Also complete COLI Consent Form

Owner's Address (If P.O. Box, include Street Address) Street City State Zip Code

Date of Birth	Social Security/Tax ID #:	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

* ☐Driver's License: #	Issue State / Country
* ☐State ID ☐Passport ☐Military ☐Permanent Resident Card: #	

9b. NAME OF JOINT OWNER ☐Individual ☐Trust–Also complete Certificate of Trust Agreement ☐Business/Corporate–Also complete COLI Consent Form

Joint Owner's Address (If P.O. Box, include Street Address) Street City State Zip Code

Date of Birth	Social Security/Tax ID #:	Relationship to Proposed Insured

Are you a U.S. Citizen? ☐ Yes ☐ No If no, provide information on your Government Issued identification below.

* ☐Driver's License: #	Issue State / Country
* ☐State ID ☐Passport ☐Military ☐Permanent Resident Card: #	

9c. NAME OF CONTINGENT OWNER:

Date of Birth	Social Security/Tax ID #

BENEFICIARY

Share percentages must equal 100%. Please use percentages in your designation for each beneficiary listed below. Fractions and dollar amounts are not accepted. Provide Beneficiary(ies) Full Name(s). If Trust, list Name and Date of Trust and complete Certification of Trust Agreement. Beneficiary designations do not apply to others covered under Children's Term Insurance Rider. If more space is needed, attach additional sheet, identify question(s), sign and date.

10. Primary

Name: KEITH Ashley Relationship to Proposed Insured: STEP-Brother

Address: 1211 Boerne CT

Date of Birth: 1972 Social Security/Tax ID: _

Telephone # with Area Code: 972 658 6113 % Share: 100

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security/Tax ID: _____

Telephone # with Area Code: _____ % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security/Tax ID: _____

Telephone # with Area Code: _____ % Share: _____

BENEFICIARY INFORMATION - Continued

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security/Tax ID: _____

Telephone # with Area Code: _____ % Share: _____

TOTAL _____ %

10a. Contingent

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security/Tax ID: _____

Telephone # with Area Code: _____ % Share: _____

Name: _____ Relationship to Proposed Insured: _____

Address: _____

Date of Birth: _____ Social Security/Tax ID: _____

Telephone # with Area Code: _____ % Share: _____

TOTAL _____ %

LIFESTYLE INFORMATION

11. Has the Proposed Insured ever used cigarettes, nicotine patches, nicotine gum, or other nicotine substitutes? ☒ Yes ☐ No

If yes, what product? ☒ Cigarettes ☐ Nicotine patches ☐ Nicotine gum ☐ Other: Cigarettes ½ pack day

If yes, was use of the product within: ☒ last 12 months ☐ last 24 months ☐ last 36 months ☐ last 60 months ☐ 60+ months

11a. Has the Proposed Insured used tobacco in pipe or cigar form in the last 12 months? ☐ Yes ☒ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

PAYOR / BILLING INFORMATION

12. PAYOR: ☐ Proposed Insured ☐ Owner ☐ Joint Owner ☐ Other _____

If Other, provide Date of Birth: _____ (Print Full Name)

Billing Address: ☐ Check this box if billing address is same as residence previously provided, otherwise list below.

(If P.O. Box, include Street Address) Street City State Zip Code

Social Security/Tax ID#: Relationship to Proposed Insured:

Are you a U.S. Citizen? ☐ Yes ☐ No If No, provide information on your Government Issued identification below.

☐ Driver's License: # Issue State / Country

☐ State ID ☐ Passport ☐ Military ☐ Permanent Resident Card: #

PREMIUM INFORMATION

Distributions from a qualified plan or individual retirement account (IRA) cannot be used as premium for this policy. Will funds from a qualified plan or IRA, other than required minimum distributions (RMDs), be used to pay all or a portion of the premiums for this policy?..... ☐ Yes ☐ No

13. Premium Frequency: ☐ Annual ☐ Semi-Annual ☒ Quarterly ☐ Monthly ☐ Single Pay

☐ Lump Sum $_____ Source of Lump Sum: _____

14. Payment Type: ☐ Electronic Fund Transfer (EFT) – Complete EFT Transfer Fund Authorization

☐ List Billing – List Bill Code / Business Name: _____

☒ Direct Billing (Annual, Semi-Annual, Quarterly Only)

☐ Civil Service Allotment - Complete Direct Deposit Sign-Up Form

☐ Military Government Allotment

For term and whole life policies, if you elect to pay premium on a basis other than annual, you will pay more premium than would be required if you paid on an annual basis. Make all checks payable to: MIDLAND NATIONAL LIFE INSURANCE COMPANY.

15. Amount of Modal Premium: $ 7,000.00

16. Amount Paid with Application: $ 0

17. Payment of Initial Premium – (check one):

☐ I have elected Temporary Life Insurance Agreement (TIA) with this Application and have completed the TIA form. The Owner(s) has/have elected payment of the initial premium by EFT or Check and has read, understands, and agrees to the terms of such Agreement. (When submitting premium, the TIA form is required.

☐ This application is C.O.D. with No Temporary Insurance Coverage. (TIA not intended).

18. Third Party Billing Notification – Optional - Complete this section to designate an additional person to receive Grace Period notices for insufficient premium and lapse notices.

Name of Designated Person: _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone # with Area Code: _____

REPLACEMENT AND EXISTING COVERAGE INFORMATION

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase. This includes policies or certificates that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements, or that will be replaced, canceled, or sold.

NOTE: If your current policy is replaced, you may pay a surrender charge. When a new policy is purchased, the surrender charge and other applicable provisions will start anew.

19. Does any person proposed for coverage, including Dependents, have any life insurance or annuities currently in force or pending?

☐ **Yes** ☒ **No**

1) If the response to the above questions is "Yes", provide information on existing insurance below.
2) Complete applicable Replacement Notice form and submit with this application.

If more space is needed, attach additional sheet, identify question(s), sign and date

	Existing Policy/Certificate 1	Existing Policy/Certificate 2	Existing Policy/Certificate 3	Existing Policy/Certificate 4	Existing Policy/Certificate 5
Company Name					
Policy/Certificate Number					
Year Issued					
Death Benefit	$	$	$	$	$
ADB Amount	$	$	$	$	$
In force or Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending	☐ In Force ☐ Pending
Will this Policy/Certificate be changed or replaced?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
1035 Exchange	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

20.	Has, or will, the Proposed Insured or Owner of this policy been, or be, compensated in any way to purchase this policy?	☐ Yes ☒ No
21.	Is the Proposed Insured or Owner of this policy, paying for this policy with his/her own funds?	☒ Yes ☐ No
22.	Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy?	☐ Yes ☒ No
23.	Has the Proposed Insured or Owner of this policy financed, or intend to finance, all or a portion of the premiums for this policy?	☐ Yes ☒ No
24.	Has the Proposed Insured, Owner, or Beneficiary entered into, or considering entering into, any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests?	☐ Yes ☒ No

If the answer is 'Yes' to questions 20, 22, 23, or 24 provide details below. If answer is 'No' to question 21, provide details below. If more space is needed, attach additional sheet, identify question(s), sign and date.

25. SPECIAL REQUESTS OR DETAILS

I will order exam.

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)
If the Proposed Insured is the Owner, also complete Military Sales Disclosure Form.

26. Job Duties

27. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

28. Military Information ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) _____
Military ID _____
Pay Grade: Rotation Date: Expected Discharge Date:

29. Has the Proposed Insured applied to be a member of, or been a member of, a special forces, or a special or hazardous duty organization?
☐ Yes ☐ No If yes, provide specific details.

30. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment?
☐ Yes ☐ No If yes, provide specific details.

UNDERWRITING QUESTIONS

Details to "Yes" answers are to be provided in the Details Section below.

	Yes	No
31. In the past 10 years, has the Proposed Insured:		
a. Used barbiturates, hallucinatory drugs, narcotics, including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs, or been advised by a licensed medical professional to get medical treatment or undergone any medical treatment, counseling or hospitalization for drug abuse? If yes, complete Drug Questionnaire	☒	☐
b. Been advised by a licensed medical professional to limit your alcohol use or been advised to get medical treatment, or undergone any medical treatment or counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or medical treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day? If yes, complete Alcohol Questionnaire.	☐	☒
c. Had your driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol or drugs (DWI, DUI)?	☐	☒
d. Pled guilty to or been convicted of a felony or misdemeanor? If yes, provide details on the nature of the plea or conviction, the date and state where the plea or conviction occurred, and whether time was served in prison.	☐	☒
e. Been refused for life insurance or charged an extra premium for life insurance?	☐	☒
32. Has the Proposed Insured:		
a. Within the past five years, had his/her driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol and/or drugs (DWI, DUI)?	☐	☒
b. Within the past five years, had more than one speeding violation or, motor vehicle moving violation, been involved in any accident in which he/she was found to be at fault, or pled guilty or been convicted for driving under the influence of alcohol?	☐	☒
c. Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? If yes, complete Aviation Questionnaire.	☐	☒
d. In the past 12 months or in the next 12 months, engaged in or plan to engage in the following recreational activities: hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas? If yes, complete applicable Underwriting Questionnaire.	☐	☒
e. Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? If yes, complete Foreign Travel and Residence Questionnaire.	☐	☒
f. Had or have any bankruptcy pending or expect to file bankruptcy in the next 12 months?	☐	☒

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 31 THROUGH 32.

If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Dates and Details
31A	Client Smokes Marijuana on occasion Aprox 1 a week.

Questions 33 through 36 must be completed for Proposed Insureds NOT subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

	Yes	No
33. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get medical treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):		
a. Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur?	☐	☒
b. High blood pressure, hypertension or abnormal cholesterol levels?	☐	☒
c. Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder?	☐	☒
d. Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles?	☐	☒
e. Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma?	☐	☒
f. Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia?	☐	☒
g. Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea?	☐	☒
h. Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands?	☐	☒
i. Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine?	☐	☒
j. Anemia, hemophilia, clotting disorder or any other disorder of the blood?	☐	☒
k. Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus?	☐	☒
l. Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas?	☐	☒
m. Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition?	☐	☒
34. Other than indicated above, has the Proposed Insured:		
a. In the past 5 years, been diagnosed, treated or advised to get medical treatment from a licensed medical professional for any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☒
b. Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, provide age at death.	☐	☒
c. Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy?	☐	☒
d. Except for tests related to Human Immunodeficiency Virus (AIDS virus), in the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test, or sought medical advice or treatment for any reason?	☐	☒
e. In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility?	☐	☒
35. Is the Proposed Insured currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.	☐	☒
36. Is the Proposed Insured currently receiving or have an application pending for any illness or disability benefits or compensation?	☐	☒

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 33 THROUGH 36.
If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

DETAILS TO 'YES' ANSWERS FOR QUESTIONS 33 THROUGH 36 - Continued

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital
	N/A	

37. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years.

N/A

a. Date and findings of last visit:

over 10 yrs ago ~~had~~ never sick, client states.

b. Tests performed and treatment received:

N/A

c. Do you have medical records under any other name? ☐ Yes ☒ No If yes, please provide details here.

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary; (2) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Midland National Life Insurance Company (the Company); and (3) No change in amount, risk classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured, that arises or is discovered after completing this application, but before the policy is effective, as defined herein.

Effective Date – Any insurance issued as a result of this application will either: (1) not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Life Insurance Agreement, if issued.

IRS SUBSTITUTE W-9 TAX PAYER IDENTIFICATION NUMBER CERTIFICATION – To be completed by Owner. (If Joint Owners, to be completed by owner who assumes tax liability.) Under penalties of perjury, as Owner of this policy, I certify that:

1. The taxpayer identification number shown on this application is my correct taxpayer identification number;
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. Check this box ☐ if you ARE subject to backup withholding;
3. I am a U.S. citizen or other U.S. person as defined by the IRS for federal tax purposes;
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorizes any licensed physician, licensed medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, MIB, Inc. (MIB), consumer reporting agency, insurance support organization, independent administrator, or governmental agency or group policyholder, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children proposed for insurance and any other nonmedical information of the Proposed Insured or minor children proposed for insurance to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I also authorize the Company to conduct a personal telephone interview in connection with my application. I further authorize the Company to collect information about me from public and non-public sources, including my Social Security number, financial and credit history, employment, general character and reputation, personal characteristics and mode of living. I authorize the Company to release any information obtained to its reinsurers, MIB, or other persons or organizations performing business or legal services in connection with my application or to persons or organizations performing services on behalf of the Company for other business or marketing purposes, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid from the date signed for the length of time permitted by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

The undersigned applicant(s) acknowledges receipt of the Consumer Protection Notice that includes the Fair Credit Reporting Act Notice/MIB, Inc., Notice and Notice of Insurance of Information Practices.

ACCELERATED DEATH BENEFIT(S): If the policy being applied for includes an accelerated death benefit(s) endorsement or rider, the Owner understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent provided the Owner an Accelerated Death Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURES

Signed at (Solicitation City and State): ALLEN TX	Date: 2-26-2018
Signature of **Proposed Insured** (Parent/Legal Guardian Signature, if Proposed Insured is a Minor) X [signature]	

Signature(s) of **Owner / Joint Owner** (If other than Proposed Insured)
(If Owner is a Corporation, Trust or other Entity, include Title of Signee. For a Corporation, a Corporate Resolution is needed including signatures of two officers and their titles.)

X

X

X

Community Property: If this transaction is subject to a community property or civil union interest, we strongly recommend the Owner/Joint Owner obtain his/her spouse's signature to document his/her consent to this transaction. The Owner/Joint Owner understands and agrees the Company may presume that no such interest exists if the Owner/Joint Owner has not obtained his/her spouse's signature. Further, the Owner/Joint Owner understands and agrees the Company has no duty to inquire further about any such interest. As a result, the Owner/Joint Owner agrees to indemnify and hold the Company harmless from any consequences relating to community property or civil union interests and this transaction.

Please note that the term "Spouse" includes domestic partner or other partner as permitted by civil union, domestic partnership or similar law. Likewise, the term "civil union" is intended to mean civil union, domestic partnership or other marriage-like arrangement permitted by law.

Signature of **Owner's Spouse** for Community Property States Check this box ☐ if Spouse's Signature WILL NOT be obtained.	Signature of **Joint Owner's Spouse** for Community Property States Check this box ☐ if Spouse's Signature WILL NOT be obtained.
X N/A	X N/A

TO BE COMPLETED BY SOLICITING AGENT **Commission Option: (check one)** ☒ A ☐ B ☐ C ☐ D

1. If the policy being applied for includes an accelerated death benefit(s) endorsement or rider, was the Owner provided the Accelerated Death Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application? ..... ☒ Yes ☐ No
2. Does any person covered under this application have any existing life insurance or annuities? ..... ☐ Yes ☒ No
3. Is any insurance applied for in this application intended to replace any existing life insurance or annuity? ..... ☐ Yes ☒ No
4. The Company approved all sales material that I used with respect to the solicitation of the application for the policy. A copy of all sales material was left with the applicant(s), including a printed copy of all such sales material presented electronically. ..... ☒ Yes ☐ No

Signature of **Soliciting Agent** X	Print Agent's Last Name	Agent Code
	Keith T. Ashley	OYR6
Telephone Number	Mobile Phone Number 972 658 6113	

Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code
Other Agent (Print)	% Credit	Agent Code

MIDLAND NATIONAL Life Insurance Company

9542

Drug Questionnaire

Name of Proposed Insured:	Date of Birth:
Paul Villarreal	1962

1. Do you now, or have you in the past, used any of the following substances:

	Yes	No	Date Last Used	Present	Amount	Length of Time
A) Opiates: Heroin, Codeine, Morphine, Methadone, Demerol, etc.	☐	☒				
B) Barbiturates: Amytal, Phenobarbital Seconal, Nembutal, etc.`	☐	☒				
C) Non-Barbiturates: Phacidyl, Doriden, Quaalude, etc.	☐	☒				
D) Amphetamines: Benzedrine, Dexedrine Methedrine, Designer Drugs, etc.	☐	☒				
E) Methamphetamine: Cocaine, Crack, Ice, etc.	☐	☒				
F) Hallucinogens: LSD, Peyote, Psilocybin MDA, Mescaline, etc.	☐	☒				
G) Cannibus: Marijuana, Hashish, etc.	☒	☐	Week ago	yes	1 Cigarette	over 10yrs
H) Any other substances not listed Above? Substance Name: _____	☐	☒				

2. Have you ever seen a doctor or sought or been advised to seek medical treatment or counseling for drug abuse? Yes ☐ No ☒

Dates/Details: N/A

3. Have you ever been charged with driving under the influence or had other traffic violations/accidents where drugs were involved? Yes ☐ No ☒

Dates/Details:

4. Have you ever been arrested or charged with possession, use or sale or distribution of illegal substances? Yes ☐ No ☒

Dates/Details:

5. Are you now, or were you ever, a member of Alcoholics Anonymous, Narcotics Anonymous or similar organizations? Yes ☐ No ☒. If yes, how long a member? _____ How often attended? _____

I hereby agree that all statements and answers to the above questions are true and complete to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at:	Date:
Allen	2-26-2018
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each additional page.

9542

Prt. 11/04

MIDLAND NATIONAL Life Insurance Company

7507A

INDEXED UNIVERSAL LIFE INSURANCE

As a valued customer of Midland National Life Insurance Company (the Company), We want to make sure You understand the unique features of the indexed life insurance Policy or Certificate for which You have applied. The Policy or Certificate may earn interest based on the movement of the selected Index(es), but will never credit less than zero percent. While earnings are based on the Index(es) You select, premiums are not invested in stocks, bonds or equity investments, and the Index growth does not include dividends.

The Policy or Certificate for which you have applied is not registered as a security. Therefore, purchasing this indexed life insurance Policy or Certificate is not the same as making an investment directly in the stock market. This summary is not intended to be a full description of the Policy or Certificate. Please refer to your Policy or Certificate when issued for complete details and definitions.

XL-CV5, XL-DB4 and XL-EC5

ALLOCATION CHOICES

You may direct Your money among the Fixed Account and/or any combination of the following Indexes:

1. The Standard & Poor's 500® Composite Stock Price Index (S&P 500®)
2. The Nasdaq-100® Stock Price Index
3. The S&P MidCap 400®
4. The Russell 2000®
5. The EURO STOXX 50®

Legacy Guaranteed SIUL

ALLOCATION CHOICES

You may direct Your money among the Fixed Account and/or any combination of the following Indexes:

1. The Standard & Poor's 500® Composite Stock Price Index (S&P 500®)
2. The Dow Jones Industrial Average® (DJIA®) Composite Stock Price Index
3. The Nasdaq-100® Stock Price Index
4. The S&P MidCap 400®
5. The Russell 2000®
6. The EURO STOXX 50®

INDEX CREDITING METHODS

The interest credited to the Policy or Certificate is calculated through the use of one of the following methods: the Daily Averaging method, the Annual Point-to-Point method, the Annual Point-to-Point with Spread method, the Monthly Point-to-Point method or the Multi-Index Annual Point-to-Point method. No Index Credits will be applied until the end of the Index Period and money withdrawn or surrendered prior to this time will not receive Index Credits. The examples shown below for each Crediting Method use hypothetical values based on non-guaranteed values and are not intended to predict or project actual performance of any Index.

When the **Daily Averaging** (only available on Legacy Guaranteed SIUL) method is chosen, the Index change is determined by calculating the difference between the Index Value on the first day of the Index Period and the average Index Value throughout the Index Period. The Index change is subject to the Index Participation Rate and Index Floor Rate (these items are defined below). The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period. The Daily Averaging crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000® and DJIA®.

When the **Annual Point-to-Point** method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index change is subject to the Index Cap Rate, Index Participation Rate, and Index Floor Rate. The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period. The Annual Point-to-Point crediting method is available for the S&P 500®, S&P MidCap 400®, Russell 2000®, DJIA®, EURO STOXX 50®, and NASDAQ-100®. The S&P 500® includes both a capped and an uncapped version of this crediting method.

Agent Instructions: Provide the Owner a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA
Phone: (605) 335-5700 • New Business Fax - Red Team: (877) 212-1057 Blue Team: (877) 212-1704 Green Team: (877) 212-1703 • Fax Center: (877) 208-6136 • MidlandNational.com

When the **Annual Point-to-Point with Spread** (only available on XL-CV5, XL-DB4 and XL-EC5) method is chosen, the Index credit is determined by calculating the change between the Index Value on the first day of the Index Period and last day of the Index Period. The Index change is multiplied by the Index Participation Rate, and then the Index Spread Rate is deducted. The rate credited at the end of the Index Period will never be less than zero percent (the Index Floor Rate). The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period. The Annual Point-to-Point with Spread crediting method is available for the S&P 500®.

When the **Monthly Point-to-Point** method is chosen, the Index credit is determined by calculating the 12 Monthly Index Returns, which are determined by the change in the Index during the month multiplied by the Index Participation Rate. The Monthly Index Return can not be greater than the Monthly Index Cap Rate and it can be a negative number. At the end of the 12-month Index Period, the 12 preceding Monthly Index Returns are added together to determine the Index Credit, which is credited and locked in at the end of the 12-month Index Period. The rate credited at the end of the Index Period will never be less than zero percent (the Index Floor Rate), and will never be greater than 12 times the Monthly Index Cap Rate. The Monthly Point-to-Point crediting method is available for the S&P 500®.

When the **Multi-Index Annual Point-to-Point** method is chosen, the Index credit is determined by calculating a Multi-Index change between the first day of the Index Period and the last day of the Index Period. The Multi-Index change uses the following three indices: S&P 500®, EURO STOXX 50®and Russell 2000®. The annual point-to-point Index change from each of the three individual indexes determines the Multi-Index change. 50% of the best performing Index change plus 30% of the second best performing Index change plus 20% of the third best performing Index change equals the Multi-Index change. The Multi-Index change is subject to the Index Cap Rate, Index Participation Rate, and Index Floor Rate. The Index Credit, if any, is credited and locked in at the end of the 12-month Index Period.

OTHER ELEMENTS AFFECTING INDEX CREDITS

- **Index Participation Rate** – the portion of the Index change that is used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than the minimum shown in the Policy or Certificate.
- **Index Cap Rate** – the maximum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than the minimum shown in the Policy or Certificate.
- **Index Floor Rate** – the minimum interest rate that can be used in the calculation of the Index Credit. This rate can be changed by the Company but can never be less than zero percent.
- **Index Spread Rate** (only available on XL-CV5, XL-DB4 and XL-EC5) - the interest rate that will be subtracted from the Index growth in the calculation of the Annual Point-to-Point with Spread Index Crediting Method.
- **Minimum Policy or Certificate Account Value** – The rate credited to your Policy or Certificate at the end of each 12-month Index Period will never be less than zero percent (the Index Floor Rate). However, we will also calculate a Minimum Policy or Certificate Account Value that uses an interest rate of 3% in all Policy or Certificate years for all premiums. If your Policy or Certificate terminates (due to death, surrender, maturity, or lapse), we use the compare the Policy or Certificate Account Value using actual interest credits to the Minimum Policy or Certificate Account Value and use the greater value.
- **Surrender Charge** – the Surrender Charge is a charge made against the Policy or Certificate Account Value in the event of a surrender of the Policy or Certificate. The Surrender Charge varies by Policy or Certificate Year and is based on the Sex, Issue Age and Premium Class of the Insured. Surrender Charges apply to the initial Specified Amount. Additional Surrender Charges will apply to any increase in Specified Amount and any decrease in Specified Amount or Withdrawal will reduce the Surrender Charge. Surrender Charges vary by product.
- **Transfers from an Index Selection** – transfers out of an Index Selection can only occur at the end of a 12-month Index Period.

OWNER:

This is an indexed life insurance Policy or Certificate, and even though the values of the Policy or Certificate may be affected by an external Index, the Policy or Certificate does not directly participate in any stock, bond or equity investments.

- **The values of the external Indices do not reflect the payment of dividends.**
- **The Policy or Certificate applied for is not a registered security.**
- **Current illustrated values are based on past Index performance and are not intended to predict future performance.**
- **The Company has the right to change Index Spread Rates, Index Cap Rates, Index Floor Rates, Index Participation Rates and interest rates.**
- **Any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.**

I acknowledge that I have read this disclosure material and received a copy.

Signature(s) of **Owner / Joint Owner** (If Owner is Corporation, Trust or other Entity, include Title of Signee. For Corporation, signatures of two officers are needed.)	
X [signature]	DATE 2-26-18
X	DATE
X	DATE

AGENT:
I certify I have provided a copy to and reviewed this disclosure material with the Applicant. This application is being submitted after an examination of the interests of the Applicant and an assessment of the stated goals of the Applicant. I have discussed this product with the Applicant and have not made any statements which contradict the disclosure materials provided to the Applicant. I have not made any promises about the future performance or values of any non-guaranteed elements of any indexed life insurance Policy or Certificate. I certify that I have completed the Company's Indexed Universal Life Certification Training and passed the Agent Certification Exam.

AGENT'S SIGNATURE	DATE
X [signature]	2-26-2018

THE S&P 500® COMPOSITE STOCK PRICE INDEX;
THE S&P 400® COMPOSITE STOCK PRICE INDEX; and
THE DOW JONES INDUSTRIAL AVERAGE® (DJIA®) COMPOSITE STOCK PRICE INDEX

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S&P Dow Jones Indices have no obligation to take the needs of the Company or the owners of the Company's Product(s) into consideration in determining, composing or calculating the S&P MidCap 400® and the S&P 500® Indices. S&P Dow Jones Indices is not responsible for and has not participated in the determination of the prices, and amount of the Company's Product(s) or the timing of the issuance or sale of the Company's Product(s) or in the determination or calculation of the equation by which the Company's Product(s) are to be converted into cash, surrendered or redeemed, as the case may be. S&P Dow Jones Indices has no obligation or liability in connection with the administration, marketing or trading of the Company's Product(s). There is no assurance that investment products based on the S&P MidCap 400® and the S&P 500® Indices will accurately track index performance or provide positive investment returns. S&P Dow Jones Indices LLC is not an investment advisor. Inclusion of a security within an index is not a recommendation by S&P Dow Jones Indices to buy, sell, or hold such security, nor is it considered to be investment advice.

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In addition, CME Group Inc. and its affiliates may trade financial products which are linked to the performance of the S&P MidCap 400® and the S&P 500® Indices.

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MIDLAND NATIONAL®
Life Insurance Company

4913TX

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or and AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that you application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If you test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

Physician:
Address:
City/State/Zip Code:

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian Paul Villarreal
Name of Proposed Insured Paul Villarreal
Address 959 N. Washington St
City, State, Zip Code Farmersville TX
Date Signed 2-26-2018

4913-TX

Rev. 4/10F

MIDLAND NATIONAL® Life Insurance Company

8701

Authorization for Release of Health-Related Information
This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured (Please print)	Birth Date
Paul Villarreal	Month / Day / Year 1962

I authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed and that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Midland National Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Midland National Life Insurance Company may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Midland National Life Insurance Company.

Midland National Life Insurance Company • Administrative Office: One Sammons Plaza, Sioux Falls, SD 57193 • Principal Office: West Des Moines, IA • MidlandNational.com

Agent Instructions: Provide the Proposed Insured a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.

This Authorization shall remain in force for 30 months (24 months in AK, AR, CA, CO, FL, IA, IN, KS, KY, MD, MS, MT, NE, NH, ND, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, WV & WY) following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Midland National Life Insurance Company at One Sammons Plaza, Sioux Falls SD, 57193, Attention: New Business.

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Midland National Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, Midland National Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge by my signature below, that I or my Personal Representative has a right to receive, and have in fact received, a copy of this authorization.

Signature of Proposed Insured or Personal Representative	Date
Paul Villarreal	2-26-2018

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

_____

_____

Agent Instructions: Provide the Proposed Insured a copy of this form; submit one copy to the Administrative Office and keep a copy for your records.